THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER
WASHINGTON DC

SCHOOL OF PUBLIC HEALTH
& HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY
CENTER FOR HEALTH SERVICES RESEARCH &
POLICY

# Medicare Physician Payment:

# How to Build a More Efficient Payment System

Statement of

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Before the

House Committee on Energy and Commerce

Subcommittee on Health

November 17, 2005

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Chairman Deal, Ranking Member Brown, and members of the Subcommittee on Health of the House Energy and Commerce Committee, I am Nora Super, a senior research associate at George Washington University's Center for Health Services Research and Policy. I appreciate the opportunity to be here today to discuss how to build a more efficient physician payment system for the Medicare program.

As a health services researcher from George Washington University, I study many broad aspects of the Medicare program, ranging from implementation of the new drug benefit to coordination of care for those who are dually eligible for Medicare and Medicaid. Nonetheless, physician payment reform continues to be one of the most challenging and important issues facing the program today. Many experts have concluded that improving the quality of care ultimately requires changes in individual physician behavior.[1] However, aligning incentives at the national level to reduce inappropriate care while simultaneously improving quality have thus far proved elusive.

**Drivers in Fee-For-Service Utilization**

As you know, the vast majority of Medicare beneficiaries receive care under Medicare's fee-for-service system. In fee-for-service medicine, the incentives are clear: a physician or other practitioner charges separately for each patient encounter or service rendered. Under this payment system, expenditures and incomes increase if more units of service are provided or more expensive ones are substituted for less expensive ones. Thus, individual physicians have an

incentive both to increase the volume of patients that they see, and to recommend the highest cost and best reimbursed procedures under these incentives.

Physicians, like anyone, respond to incentives. Under the fee-for-service system, physicians are paid based on the number of procedures or encounters provided and are paid much more generously for doing interventional procedures, such as coronary stenting or colonic polypectomy than they are for so-called evaluation or management services—time spent with a patient and family weighing the benefits and risks of alternatives and/or discussing treatment options.

I recently completed a case study of a multi-specialty physician practice group that switched to fee-for-service reimbursement after nearly 30 years as a capitated-based medical group in Cincinnati, Ohio.[2] The group did not do so willingly, but in response to an evolving marketplace that no longer rewarded small capitated products. Nevertheless, the physicians in the 100+ physician group quickly responded to the changed financial incentives by seeing patients more frequently and ordering more tests, demonstrating that payment incentives can markedly change the way physicians practice medicine.

Under the fee-for-service system, it is faster and therefore more remunerative for a physician to order more tests or procedures than to spend time with patients, for example, discussing recommended preventive services to help them manage their chronic diseases. Sicker patients, with multiple chronic conditions, are likely to take up more of a physician's time. However, our

current system does not reward physicians for doing so. According to a study by Duke University Medical Center, the amount of time spent with a patient in discussing preventive services can increase three-fold if one or more chronic conditions are uncontrolled at the time of the patient visit.[3] Under the current payment incentive structure, physicians are encouraged to avoid these patients rather than to embrace them.

At present, Medicare makes no distinctions based on appropriateness or quality of care—a physician who orders or performs procedures that are not truly necessary or indicated is paid better than one who is judicious and conservatively employs complex interventions only when the cost-effectiveness is clear and the benefit clearly outweighs the risks. Essentially, physicians who see more patients per hour, do more procedures, and make and receive the most specialty referrals, make more money. In contrast, lengthy discussions with patients and their family members to discuss treatment options are reimbursed at much lower rates, if at all, for roughly the same amount of physician time. For example, the national average Medicare reimbursement for placement of two coronary artery stents via cardiac catherization was $1,012 in 2002; a two-hour family meeting was reimbursed on average between $75 and $95.

One of the explicit objectives of the Resource Based Relative Value Scale (RBVBS) physician fee schedule that was implemented in 1992 was to redistribute payment in such a way that rates for “cognitive” or “evaluation and management” services (as they are called today) would rise relative to other services, such as surgery and other procedural services. However, preliminary work done by the Urban Institute on behalf of the Medicare Payment Advisory Commission has

found that the desired redistribution has stopped for a number of reasons, primarily the interaction between changes in the relative value units (RVUs) and the growth in the volume of services, as well as the effects of introducing new services.[4]

**Valuing Physician-Patient Communication: Palliative Care as a Model within the Current System**

An example of the benefits of care focused on quality of life, maximizing clear doctor-patient communication, and expert coordination of care across settings may be found in the recent rapid growth of palliative care services and specialists in the U.S. Through research funded by the Center to Advance Palliative Care – a national program initiative of the Robert Wood Johnson Foundation based at the Mount Sinai School of Medicine in New York City – I have learned that meeting the needs of the most complex and vulnerable Medicare beneficiaries will require physicians to employ skills that are not recognized or rewarded in the current Medicare payment system.[5] Studies of doctor-patient communications have found that clinicians typically fail to discuss patients' values, goals of care, and preferences regarding treatment.[6] Not only are these skills rarely taught in medical school, any physician who tries to provide these services will soon be forced out of practice due to under-reimbursement. Physicians in practice quickly learn what they have to do to pay their overhead and themselves—see more patients faster and spend most time doing the highest-paid procedures. Talking to patients and families, managing complex symptoms, coordination and communication of care across settings—the kind of care patients

and families say they want[7] and what most of us would agree we would want for ourselves and our loved ones—is a sure path to bankruptcy under the current physician payment system.

Let's look for a moment at what we might we gain if health care financing actually created incentives for this kind of high quality care. Palliative care is a growing service in hospitals and nursing homes in the U.S., and is a response to abundant evidence of poorly treated pain and other symptoms. It aims to relieve suffering and improve quality of life for patients with multiple chronic conditions and advanced illnesses. It is offered simultaneously with all other appropriate medical treatment and is not limited to the care of the terminally ill. In practice, palliative care involves expert pain and symptom assessment and management, communication among the patient, family and providers about the goals of care, and coordination of care across multiple settings.[8] Studies demonstrate that palliative care is effective at reducing suffering of all causes, and those patients and families are more satisfied when they receive it.[9]

Interestingly, in addition to improving quality of care, multiple studies have demonstrated that palliative care also reduces spending. Data demonstrate that palliative care lowers costs (for hospitals and payers) by reducing hospital and intensive care unit length of stay, and by reducing direct costs per day (such as pharmacy and imaging utilization).[10] Palliative care achieves these outcomes in a low-tech but highly intensive and time consuming discussion—clarifying goals of care with patients and their families and helping them select medical treatments and care settings that meet their goals. This kind of in-depth conversation about the benefits and burdens of treatment alternatives often lead to more resource-conservative decisions on the part of

patients—-such as going home rather than remaining in the hospital—but there is no way to help patients and families make these difficult decisions without a major commitment of physician time and effort— time and effort which is rewarded at less than 10 percent of the level we reimburse invasive cardiologists for placing coronary stents.

These findings are especially significant for patients with chronic illnesses. We know that Medicare per capita spending increases as health status declines. For example, Medicare spends twice as much for beneficiaries living in long-term care facilities than what it spends for those living in the community. Medicare spending is also much higher for the sickest beneficiaries—those in their last year of life. In 1999, Medicare spending reached $24,856 for beneficiaries who died that year compared to $3,669 for those who were alive at the conclusion of the year.[11]

More than 80 percent of Medicare beneficiaries have at least one chronic condition, and the prevalence of chronic conditions, which typically require ongoing care and treatment to maintain health and functional status and to slow the progression of the disease, has been strongly linked to high utilization of medical resources. More than 75 percent of high cost Medicare beneficiaries were diagnosed with one or more of seven major chronic conditions (e.g., chronic obstructive pulmonary disease, congestive heart disease, diabetes).[12] A striking *68 percent* of all Medicare spending is spent on the 23 percent of Medicare beneficiaries with five or more chronic conditions and these patients receive services from an average of 14 different physicians each year.[13] The clinical need for care coordination is immense.

Yet our payment system not only fails to incent high quality management of such patients with proven palliative care approaches, it powerfully rewards and encourages through its payment methods just the opposite—more costly procedures, more specialist visits, and more hospital stays for the patients least likely to benefit from them. Jack Wennberg's data from the Center for Evaluative Clinical Sciences at Dartmouth suggests that the higher utilization that results from current Medicare payment incentives is not only not associated with improved quality of care for seriously ill Medicare beneficiaries, counter to the prevailing assumption, more services are actually associated with *higher* (not lower) mortality. In contrast, a healthcare system that provided comprehensive palliative care as the default approach, rather than the exception, would result in more satisfied patients and families, a lower burden of pain and suffering, equivalent or better survival rates, and markedly lower but more appropriate use of complex high cost procedures and care settings.

**Changing the Incentives: Is Paying for Performance the Answer?**

The latest fascination in Washington and in the business community has been a move to influence physician behavior by paying for health care services based on quality of care. "Pay-for-performance" seeks to reward physicians and other health care providers for delivering health care services that meet specified standards or achieve defined levels of quality. These payment methods have been adopted across the country by public and private purchasers with some demonstrated success; however, they face important impediments and challenges too. Most

notably, the incentives are not likely to change physician behavior unless they apply to "enough patients to make a noticeable difference in office income."[14]

As the single largest purchaser of care, many have concluded that the Medicare program must begin to link payments to physician behaviors demonstrably linked to better outcomes. CMS has several pay-for-performance pilot and demonstration projects underway. Congressional leaders and the Medicare Payment Advisory Commission (MedPAC) have also stepped up efforts to align the incentives of Medicare's payment systems to improve the quality of care. A key component of MedPAC's vision for paying for performance is that Congress "should pay more to physicians with higher quality performance and less to those with lower quality performance."[15] Recognizing that the current FFS payment system encourages individual physicians to increase the volume of services they provide, MedPAC also recommends measuring physician resource use over time and providing information about practice patterns confidentially to physicians. Given that Medicare payment systems are currently negative or neutral toward quality, these efforts are important steps in the right direction.

At the same time, clinicians and advocates have raised concerns that P4P could create adverse incentives for physicians seeking to deliver high quality care to patients with multiple chronic conditions and advanced complex illness.[16] Quality of care for this very costly and very sick patient population involves more than remembering to order a mammogram—one of the measures associated with higher pay for performance. In fact a mammogram, or a bone density test or a gait assessment may be impossible or completely irrelevant to the care of some of these

patients—such as a bed-bound person with advanced dementia and recurrent pneumonias. Despite the fact that this highly complex chronically ill population accounts for over two-thirds of Medicare spending, the physicians caring for them will be predictably paid less for failing to conduct these procedures, even though they are delivering high quality care tailored to the needs of this particular subset of beneficiaries. An undifferentiated P4P process could create strong monetary incentives to care only for younger healthier Medicare beneficiaries, those for whom the P4P quality measures were developed and in whom they make sense. If P4P is to be relevant to the costliest Medicare beneficiaries it will have to utilize measures truly correlated with quality care in this patient population—things like assessing and treating pain, conducting family meetings, and completing advance directives. Thus I conclude that we cannot simply adopt programs that have been successful in (younger) commercial populations and assume they will transfer seamlessly to the Medicare population. Adjustments will need to be made.

**Conclusion**

Medicare's attempt to control volume through its sustainable growth rate (SGR) system has been widely recognized as flawed. National volume controls, such as the SGR, are based on a faulty assumption—that physicians have a collective incentive to reduce the volume of services. To the contrary, when fees are reduced, individual physicians have an incentive to increase the number of services they provide in an effort to keep income steady. Thus, across-the-board fee reductions ultimately penalize the most prudent physicians and reward those who do more procedures and provide more, not necessarily better, services.

We cannot assume that the market alone will ensure that appropriate services are rendered. Indeed, cost escalation is almost guaranteed without some controls. A thought-provoking analysis of 12 markets over time by prominent researchers at the Center for Studying Health System Change concluded that market forces alone were limited in their ability to deliver efficient health care systems, mostly because of local provider market power vis-à-vis payers and patients.[17] As both public and private purchasers look for ways to align the incentives to improve the quality of care as well as reduce inappropriate care, financial incentives should be targeted to promote high value and efficient resource use under Medicare's fee-for-service system. The demonstration and pilot projects being undertaken by CMS in the fee-for-system to study ways to improve care for beneficiaries with high medical costs and chronic conditions will give us important information about how to better care for patients.[18] However, the underlying physician payment system – and the incentives inherent within it – must be addressed if we are to achieve any significant improvements over the long term.

The Medicare system of the future should assure access to a well trained primary care physician who is compensated as well for his time and effort as his colleague doing cardiac catheterization across the street. If society rewards high quality primary care physicians, allowing them to make a good living commensurate with their lengthy training and sufficient to repay their medical student loans, the best and the brightest will stop flocking solely to highly subspecialized and highly compensated procedural specialties. Data from the new field of palliative care suggests that comprehensive management of the sickest and most complex patients not only measurably

improves quality of care and patient satisfaction, but does so at substantially lower cost to Medicare. This kind of rational system—where chronically ill elderly patients and their families can reliably expect expert continuity of care—is within our reach. If we want to effectively redesign the Medicare payment system, we need to make sure we pay for the performance Medicare beneficiaries really need.

Notes

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